Regional consultation with Member States on the implementation of the WHO global strategy to reduce the harmful use of alcohol since its endorsement, and the way forward

Meeting Report

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1 EXECUTIVE SUMMARY

The Seventy-second World Health Assembly in May 2019 requested the World Health Organization (WHO) Director-General to "report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of the WHO Global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward" (decision WHA72.11). During the discussions at the 72nd World Health Assembly, the WHO Director-General committed that "the report will be elaborated in full consultation and engagement with Member States" and requested that this be reflected accordingly in the official records.

In response to decision WHA72.11, a regional consultation with Member States of the Americas was organized on September 19-20 at the Pan American Health Organization (PAHO) Headquarters in Washington D.C., USA. Focal points were appointed by the Ministry of Health of 30 countries to participate at the meeting and to discuss the current situation regarding alcohol and health in the Americas, the progress made at global, regional and national levels, as well as identify setbacks in the implementation of policies and interventions. They were also asked to make recommendations on how Member States could move forward in reducing the harmful use of alcohol at all levels.

There has not been progress in reducing the total per capita alcohol consumption in the world in comparison to 2010, except for the European Region. No changes were observed in the Americas. The current trends and projections point towards increase of total per capita consumption worldwide and in the Americas in the next 10 years, that will make the target of 10% relative reduction by 2025 out of reach unless implementation of effective alcohol control measures are implemented in large countries with high consumption levels.

Currently available data indicate that the prevalence of drinkers in the region of the Americas is the highest in the world. At the same time, there is a very high mean level of alcohol consumption among drinkers, amounting to 32.8 grams per day among men and women combined, and more than 43 grams per day among men (15.4 grams per day for women). These levels of alcohol consumption are associated with significant health risks. Hence, one of the priority areas for global and regional action is to reduce the levels of alcohol consumption among drinkers.

The situation in the Americas regarding alcohol policy development and implementation is of concern, as most countries do not have an adopted written national alcohol policy. Funding for implementation continues to be scarce and insufficient, especially in the Americas. Most countries have not adopted the most cost-effective policies ("best buys") neither the WHO recommended drink driving laws. Treatment coverage for alcohol dependence as well as for screening and brief interventions for excessive alcohol use remain unknown and estimated to be very low. Awareness-raising activities are common, but 30% of countries providing information to WHO indicate that these are funded by the alcohol industry, and there is substantial evidence that industry-funded initiatives are unlikely to be effective.

Since the adoption of the regional plan of action for reducing harmful use of alcohol in 2011, several achievements have been identified at regional level, including the creation and maintenance of a regional network of national counterparts dedicated to alcohol, the development of tools for capacity building at country level, including six virtual courses for self-learning on alcohol related topics, 20 technical publications and over 35 scientific publications in peer reviewed journals with data from countries in the Region, and direct technical support to the majority of countries in the region.

At the same time, the influence and interference of the alcohol industry was considered as a key barrier to making progress on the adoption of the most cost-effective alcohol policies. Among the challenges reported were the industry "retaliation" and the promotion of mixed messages around responsible drinking (without a definition), that alcohol is a healthy product with benefits in many areas of health and wellbeing.

Considerable challenges for effective alcohol policy development and implementation remain. Some of these were discussed, including the culture around alcohol constructed in part via pervasive alcohol marketing and promotion; the lack of effective enforcement of the laws; the lack of a regional or global regulatory framework that would increase country action and the gaps in knowledge and actions around managing conflicts of interest that would prevent the alcohol industry from interfering with the policy making process.

The three effective and cost-effective "best buys" of alcohol control – limiting physical availability, restricting advertising and marketing, and increasing price through taxation – are the best policy options and tools available to Member States for achieving these reductions in the harmful use of alcohol. There was a clear consensus that strengthening legislation to reduce alcohol-related harms was a leading priority among Member States. To maximize the benefits to the populations in Member States, these effective policies and interventions should be complemented by other recommended measures.

Building capacity, both within alcohol and in concert with other sectors and programs, was another leading priority. A new WHO-led initiative, SAFER, focused on the implementation of cost-effective priority interventions ('best buys") and other recommended alcohol-control measures at country level, was considered a priority for technical cooperation activities and for national action by the participants.

At regional level, the participants also recommended the dissemination of essential information for public servants working on alcohol related topics; support for activities related to preventing and understanding fetal alcohol spectrum disorders; the development of guidance on alcohol dependence and referral systems; documentation of best practices from within the region, as well as on the return of investing in the best buys; a social media took kit for campaigns, to support activities related to alcohol policies and interventions. Participants suggested that developing an online repository or communities of practice would allow countries to not duplicate efforts by sharing policies, policy templates, best practices, and skills across the region.

Participants also recommended strengthening alcohol monitoring systems, including surveillance, and that countries need to track total alcohol per capita consumption in addition to other indicators of harms, levels and patterns of drinking.

The lack of resources at all levels was also seen as a barrier to policy implementation, but it was particularly limited in the Americas. In order to use the limited funds to most efficiently reduce alcohol-related harms, participants recommended "whole-of-government" and "whole-of-society" approaches at national and international levels, with appropriate engagement of non-state actors, and particularly of public health-oriented NGOs, professional associations and civil society groups. Participants complained that the financial support for this critical work was low and that was a key reason why Member States accepted alcohol industry funding for awareness-raising activities.

Moving forward with require strong political leadership and commitment. All participants considered critical the role of WHO and PAHO in providing the tools, guidance and technical support needed to assist countries in effectively reducing harmful use of alcohol. The work of the past nine years should continue

and be expanded, using the WHO Global strategy as the framework for action, while recognizing that an international agreement for alcohol control may be a more effective way to work together globally. Overcoming the interference and influence of the alcohol industry will also require clear guidance and technical support, and it was identified as another priority area of action and collaboration.

2 CONTEXT AND INTRODUCTION

Alcohol is a psychoactive substance with toxic and dependence-producing properties. Although alcohol consumption varies considerably around the world, the health burden caused by alcohol globally is enormous. The harmful use of alcohol is among the leading risk factors for disease burden in populations worldwide. Given the magnitude and the complexity of the problem, concerted global and regional efforts must be in place to support countries and communities in the challenges they face to reduce the harmful use of alcohol. International coordination and collaboration can create the synergies that are needed and can provide increased leverage for Member States to implement evidence-based measures.

The Global strategy to reduce the harmful use of alcohol (hereafter referred to as the "Global strategy"), negotiated and agreed by the World Health Organization (WHO) Member States in 2010 (Resolution WHA63.13), represents international consensus that reducing the harmful use of alcohol and its associated health and social burden is a public health priority. In the context of this strategy, the concept of the harmful use of alcohol is broad and encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes. The consensus reached on the Global strategy and its endorsement by the WHA was the outcome of a close collaboration between WHO Member States and the WHO Secretariat.

The vision behind the Global strategy was improved health and social outcomes for individuals, families, and communities, with considerably reduced morbidity and mortality due to harmful use of alcohol and its ensuing social consequences. The strategy contained a set of principles to guide the development and implementation of policies at all levels; it set priority areas for global action and recommended target areas for national action. The strategy gave a strong mandate to WHO to strengthen action at all levels.

As a result, the Directing Council of the Pan American Health Organization (PAHO) adopted (Resolution CD51/8 Rev.1) the Plan for Reducing Harmful Use of Alcohol, fully consistent with the Global strategy in 2011, and focused on technical cooperation with Member States to implement it, develop and adapt tools, and disseminate information on alcohol related topics. A regional network of national counterparts was created and met three times since 2010 (Geneva 2010, Mexico 2012, and Colombia 2014).

Alcohol is one of the leading risk factors for noncommunicable diseases (NCDs) and alcohol indicators are included in the Global NCD Action Plan and Monitoring Framework for NCDs with a target of reducing harmful use of alcohol by 10% by 2025. Appendix 3 of the NCD action plan contains a menu of policy options and cost-effective interventions for the prevention and control of harmful use of alcohol. Appendix 3 has recently been updated to take into consideration the emergence of new evidence of cost-effectiveness and the issuance of new WHO recommendations. The most cost-effective interventions to reduce the harmful use of alcohol, or 'best buys', are: (i) increasing excise taxes on alcoholic beverages; (ii) enacting and enforcing bans or comprehensive restrictions on alcohol advertising; and (iii) enacting and enforcing restrictions on the physical availability of retailed alcohol. Drink-driving countermeasures and the provision of brief psychosocial interventions for persons with hazardous and harmful alcohol use are further listed as effective interventions.

As one of the leading risk factors for population health worldwide, harmful use of alcohol has a direct impact on many of the Sustainable Development Goals (SDGs) and targets. Alcohol is specifically mentioned under health Target 3.5: “Strengthen the prevention and treatment of substance use, including narcotic drug abuse and harmful use of alcohol”. The inclusion of a separate health target to strengthen the prevention and treatment of substance use disorders under SDG 3 illustrates the increased diversity of the new global development agenda and its recognition of harmful use of alcohol as a development issue in itself.

As WHO sets a course in its Global Programme of Work for 2019–2023 to ensure that 1 billion more people enjoy better health and well-being by the year 2023 and 1 billion more benefit from universal health coverage, it becomes an even stronger public health imperative to effectively address the harmful use of alcohol and the need to reduce alcohol-related harm worldwide.

More recently, WHO has launched the SAFER initiative in collaboration with international partners. The objective of the initiative is to provide support for Member States in reducing the harmful use of alcohol by enhancing the ongoing implementation of the global alcohol strategy and other WHO and UN instruments. SAFER is based on the accumulated evidence of cost-effectiveness of different alcohol control measures and recognizes the need to protect public health-oriented policymaking from alcohol industry interference as well as strong monitoring systems to ensure accountability and track progress in the implementation of the SAFER interventions.

The Seventy-second World Health Assembly in May 2019 requested the WHO Director-General to “report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of the WHO Global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward” (decision WHA72.11). During the discussions at the 72nd World Health Assembly, the WHO Director-General committed that “the report will be elaborated in full consultation and engagement with Member States” and requested that this be reflected accordingly in the official records.

In response to decision WHA72.11, a regional consultation with Member States of the Americas was organized on September 19-20 at PAHO Headquarters in Washington D.C., USA. Focal points were appointed by the Ministry of Health and attended the meeting, representing 30 countries, listed in Appendix 1.

This report summarizes the main discussions and recommendations from the consultation that will form part of a final, global report to be finalized by the end of November 2019 by WHO Secretariat.

The 146th session of the WHO Executive Board from 3 to 8 February 2020 will consider the final report and will be invited to provide further guidance. Such guidance will be taken to the 73rd World Health Assembly, from 17th to 21st May 2020, when it can either be followed or request an updated report and decide on the way forward.

3 PURPOSE OF THE REGIONAL CONSULTATION

The purpose of this regional technical consultation was to ensure country level input into developing the report to be submitted by the Director General to the seventy-third session of the World Health Assembly (WHA73).

Participants at the regional consultation were presented with the current situation regarding alcohol and health in the Americas, key activities implemented at global and regional levels since 2010, on the role of the commercial determinants of health, and were invited to:

(1) review implementation of the WHO Global strategy and regional plan of action to reduce the harmful use of alcohol during the first decade since its endorsement;
(2) identify successes, challenges and setbacks in its implementation at national level; and
(3) recommend how Member States could move forward in reducing the harmful use of alcohol at all levels.

The meeting structure involved plenary presentations, group discussions and sharing of experiences among the participants. The following questions were presented for discussion to all participants, either in plenary or in small groups:

3.1 QUESTIONS FOR DISCUSSION

1. What have been the highest achievements ("success stories") in reducing the harmful use of alcohol in the implementation of the WHO Global strategy and regional action plan in your country since 2010?
2. What have been the most important setbacks in reducing the harmful use of alcohol in the implementation of the Global strategy and regional action plan in your country since 2010?
3. Based on the developments regarding alcohol policy in your country since 2010, what do you see as the most important challenges for development and implementation of alcohol policies at the national level in the future?
4. What do you see as the most important opportunities for development and implementation of alcohol policies at the national level in the future?
5. What should be priority areas for future actions to reduce the harmful use of alcohol and strengthen implementation of the Global strategy (and corresponding regional strategies and action plans) at national level?
6. What new or strengthened existing mechanisms, tools and activities are needed to reduce the harmful use of alcohol at national level and accelerate implementation of the Global (and corresponding regional strategies and action plans) strategy to reduce the harmful use of alcohol?

4 IMPLEMENTATION OF GLOBAL STRATEGY DURING THE FIRST DECADE SINCE ITS ENDORSEMENT AND THE WAY FORWARD AT NATIONAL LEVEL

Nine years have elapsed since WHO Member States endorsed the Global strategy to reduce the harmful use of alcohol. The importance of alcohol as a leading risk factor for the global burden of diseases was later reinforced by the NCD Political Declaration and Action Plan. More recently, it was highlighted in the United Nations (UN) 2030 Agenda for Sustainable Development, with a specific Sustainable Development Goal (SDG) health target on substance abuse and an indicator on total per capita alcohol consumption. The key interrelated components for global action and recommended target areas for action at national level outlined in the Global strategy continue to be relevant to reduce the harmful use of alcohol.

In 2010, it was envisaged that the Global strategy, and corresponding regional action plan, would promote and support local, regional and global actions to prevent and reduce the harmful use of alcohol. The strategy had five objectives:

7. Raise global awareness of the magnitude and nature of the health, social and economic problems caused by harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol;
8. Strengthen the knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm;
9. Increase technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol-use disorders and associated health conditions;
10. Strengthen partnerships and better coordination among stakeholders and increase mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol; and
11. Improve systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes.

The strategy also listed 10 recommended target areas for national action:

12. Leadership, awareness and commitment
13. Health services' response
14. Community action
15. Drink–driving policies and countermeasures
16. Availability of alcohol
17. Marketing of alcoholic beverages
18. Pricing policies
19. Reducing the negative consequences of drinking and alcohol intoxication
20. Reducing the public health impact of illicit alcohol and informally produced alcohol
21. Monitoring and surveillance.

A set of policy options and interventions was proposed for consideration by Member States for each of the 10 recommended target areas. This diversity of policy options was important because some policy

options and interventions would not be relevant or feasible for all Member States. In the Americas, the level of available resources at the national level was a key constraint in identifying the policies and interventions that were possible. The Region had one of the lowest levels of funding for policy development as assessed in 2016.

Given the magnitude and the complexity of the problem, the strategy set out 4 priority areas for global action:

22. Public health advocacy and partnership
23. Technical support and capacity building
24. Production and dissemination of knowledge
25. Resource mobilization

4.1 Implementation of the global strategy since its endorsement: alcohol consumption and alcohol- related harm

The harmful use of alcohol causes 3 million deaths per year, is responsible for 5.1% of the global burden of disease expressed in DALYs and continues to be one of the leading risk factors for poor health globally. Currently available data from the 2016 WHO Global Survey on Alcohol and Health and the 2015 WHO Global Survey on Alcohol Policy presented in the 2018 WHO *Global status report on alcohol and health*, indicate some progress in reducing the harmful use of alcohol in some WHO regions, but the reduction is still insufficient to improve the situation dramatically. According to the most recent estimates in a global comparative risk assessment, alcohol was the seventh leading risk factor for death and disability in 2016 and the top risk factor among the world's population aged 15–49 years.

There has not been progress in reducing the total per capita alcohol consumption in the world in comparison to 2010. Alcohol per capita consumption was reduced significantly in only one region – the WHO European Region, which surpassed the global voluntary target of 10% relative change in comparison with 2010. These figures demonstrate the feasibility of a 10% relative reduction as proposed by the NCD Global Monitoring Framework, even though it is in the region with the highest baseline level of alcohol consumption. No changes were observed in the Americas, African and Eastern Mediterranean regions, but a dramatic increase in alcohol consumption was observed in the South-East Asia Region, with some increase in the Western Pacific Region. The current trends and projections point towards increase of total per capita consumption worldwide and in the Americas in the next 10 years, that will make the target of 10% relative reduction by 2025 out of reach unless implementation of effective alcohol control measures are implemented in large countries with high consumption levels.

There were positive changes in the estimated prevalence of heavy episodic drinking in all WHO regions, surpassing the target of a 10% relative reduction in four out of six WHO regions for the population aged 15 years and older, and in three regions (Africa, Americas, and Europe) among adolescents (15–19 years of age).

Currently available data indicate that the prevalence of drinkers in the region of the Americas is the highest in the world. In this region, special efforts are needed to prevent initiation of drinking among children and adolescents, to support adults who choose not to drink alcohol and to protect all from

pressures to drink, in line with the guiding principles of the Global strategy to reduce the harmful use of alcohol.

At the same time, there is a very high mean level of alcohol consumption among drinkers, amounting to 32.8 grams per day among men and women combined, and more than 43 grams per day among men (15.4 grams per day for women). These levels of alcohol consumption are associated with significant health risks. Hence, one of the priority areas for global and regional action is to reduce the levels of alcohol consumption among drinkers.

4.2 Implementation of the global strategy: alcohol policy

The global situation regarding alcohol policy development and implementation has somewhat improved, but it is still far from accomplishing effective protection of populations from alcohol-related harm, and achieving the targeted reduction in the global level of alcohol consumption as measured by the main indicator – total alcohol per capita consumption. The good news is that more countries have written national alcohol policies, although these are most common in higher-income countries. The situation in the Americas is of concern, as most countries do not have an adopted written national alcohol policy. Funding for implementation continues to be scarce and insufficient, especially in the WHO African, Americas and Eastern Mediterranean regions. Awareness-raising activities are common, but 30% of countries providing information to WHO indicate that these are funded by the alcohol industry, and there is substantial evidence that industry-funded initiatives are unlikely to be effective. Community action projects regarding alcohol are widespread but they most frequently involve simply providing information, which is also unlikely to be effective in changing behaviour.

Laws to discourage or prevent drink–driving are a bright spot, with numerous countries having set blood alcohol concentration (BAC) limits for drivers of 0.05% or lower. Out of 35 countries in the Americas, 8 follow WHO best practice criteria for drink-driving laws. Strictly enforcing a drink driving law can reduce the number of road deaths by 6-18%. Sixteen countries in the Region test fatally injured drivers for alcohol and only six test non-fatally injured drivers. Policies offering responsible beverage service training and requiring labels to provide alcohol content have also spread globally, but just eight countries require alcohol containers to disclose the number of standard drinks they contain. Population-level access to treatment for alcohol dependence remains limited or unknown in much of the world and the estimated treatment gap in the Americas exceeds 75%.

The most significant gaps exist in terms of the critically important “best buys” related to alcohol availability. While 29 countries report an excise tax on alcohol, fewer (18) report adjusting these taxes for inflation or using other price strategies such as minimum unit pricing or bans on low-cost selling and volume discounts. For alcohol marketing, the least restrictive policies continue to be the most common, and countries in the Americas are the most likely to have no restrictions at all. Despite a global increase in countries adopting policies that limit alcohol advertising and marketing, restrictions on the fastest growing areas for this activity, the internet and social media, are rare. Restrictions on days of sale and alcohol outlet density exist in less than one-third of reporting countries globally, and 60% of countries in the Americas report limiting hours of sale. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.

Since the adoption of the regional plan of action for reducing harmful use of alcohol in 2011, several achievements have been identified at regional level, including the creation and maintenance of a regional network of national counterparts dedicated to alcohol, a network of researchers and health care providers trained and interested in alcohol screening and brief interventions in primary health care, the development of tools for capacity building at country level, including six virtual courses for self-learning on alcohol related topics, 20 technical publications and over 35 scientific publications in peer reviewed journals with data from countries in the Region, and the provision of training and direct technical support to the majority of countries in the region.

It was also noted the increase in mobilization of civil society organizations advocating for alcohol related issues, with the creation of a dedicated awareness day in Mexico and by the Healthy Caribbean Coalition. Alcohol surveillance activities have also increased, jointly done with other risk factors. There was an increase in the coordination of actions with NCDs, and Mental Health and Drug Commissions, despite the relatively low visibility given to alcohol as compared to other risks.

At the same time, the influence and interference of the alcohol industry was also considered as a key barrier to making progress on the adoption of the most cost-effective alcohol policies. Among the challenges reported were the industry “retaliation” and the promotion of mixed messages around responsible drinking (without a definition), that alcohol is a healthy product with benefits in many areas of health and wellbeing.

Considerable challenges for effective alcohol policy development and implementation remain. Some of these were discussed, including the culture around alcohol constructed in part via pervasive alcohol marketing and promotion; the lack of effective enforcement of policies; the lack of a regional or global regulatory framework that would increase country action and the gaps in knowledge and actions around managing conflicts of interest that would prevent the alcohol industry from interfering with the policy making process. Institutional barriers related to data access to inform decision making as well as the lack of multisectoral collaboration for an integrated alcohol policy with a public health goal were also identified. These were associated, inter alia, with the complexity of the problem and sometimes limited levels of political will and commitment of governments and other stakeholders to supporting and implementing effective measures to reduce the harmful use of alcohol in a context of international economic commitments and powerful commercial interests.

5 THE WAY FORWARD AT GLOBAL AND REGIONAL LEVELS TO REDUCE THE HARMFUL USE OF ALCOHOL

Many upcoming opportunities may provide a path forward for Member States aiming to reduce alcohol-related harms. Specific inclusion of a health goal in the SDGs, with a specific target oriented to the prevention of both narcotic drug abuse and harmful use of alcohol, as well as the inclusion of harmful use of alcohol as one of the key risk factors in the NCD action plan, can help to keep alcohol and alcohol policies in the global, regional and national health agendas. Alcohol is also part of the global and regional agenda related to traffic safety, prevention of violence, including violence against women and children, and is included in the PAHO Strategic Plan 2020-2025.

The focus of this section is on recommendations on how to address the challenges in implementation of the Global strategy and regional plan of action, and to improve and strengthen its implementation at all levels. This section is structured around the four priority areas for global action that were discussed at the consultation.

5.1 Public health advocacy, partnership and dialogue

Many Member States noted that the communications strategies that were successful for tobacco do not directly translate to alcohol prevention because drinkers tend to have higher incomes than smoker users and alcohol consumption is ubiquitous in the political and policy worlds. While this means that public health advocacy for alcohol must innovate to be effective, hallmarks of successful strategies are known, including a strong evidence base and avoiding moralization. In moving forward, the international discourse on alcohol control should emphasize but not be limited to NCDs. It should also make use of a "harm to others" perspective as it expands to other areas of health; the potential of this type frame is best exemplified by its success in developing clean air policies for tobacco. Public health agencies and institutions should lead the way promoting a public health agenda to reduce the harmful use of alcohol and building broad partnerships and collaborative networks at all levels. Member States also requested guidance in identifying good partners, particularly how to identify whether potential collaborators have a conflict of interest with reducing alcohol consumption.

At the international level, the broad scope and magnitude of health and social problems caused by the harmful use of alcohol require coordinated and concerted actions by the different parts of the United Nations system and regional intergovernmental organizations in the context of the 2030 Agenda for Sustainable Development. In order to use the limited funds to most efficiently reduce alcohol-related harms, Member States recommended being strategic about engaging non-state actors who could complement and support their efforts. In other words, addressing the harmful use of alcohol requires "whole-of-government" and "whole-of-society" approaches also at the international level, with appropriate engagement of non-state actors, and particularly of public health-oriented NGOs, professional associations and civil society groups. Public health can and should work to build coalitions with NGOs to support the development and adoption of evidence-based policies. While the role of civil society was clear, Member States complained that the financial support for this critical work was low and that was a key reason why Member States accepted industry funding for awareness-raising activities.

The global dialogue (therefore not considered a collaboration or partnership) with economic operators in alcohol production and trade will continue about how the industry sectors can best contribute to reducing the harmful use of alcohol within their roles as developers, producers and distributors/sellers of alcoholic beverage products. In this context, it must be underlined that regulatory controls on the market must be decided and enforced by governments, with safeguarding populations' health as the primary goal. This means that these regulations and their enforcement need to be protected from industry interference.

5.2 Technical support and capacity-building

In its Thirteenth General Programme of Work 2019−2023, WHO aims to ensure that by 2023 one billion more people enjoy better health and well-being and a further one billion people benefit from universal health coverage. In the context of reducing the harmful use of alcohol, these goals can be translated into the objectives of increasing the proportion of the population who are protected from the harmful use of alcohol by effective alcohol control policies, and increasing the proportion of people with alcohol use disorders (AUDs) and comorbid conditions who benefit from universal health coverage. The three effective and cost-effective "best buys" of alcohol control – limiting physical availability, restricting advertising and marketing, and increasing price through taxation – are the best policy options and tools available to Member States for achieving these reductions in the harmful use of alcohol. There was a clear consensus that strengthening legislation to reduce alcohol-related harms was a leading priority among Member States. To maximize the benefits to the populations in Member States, these effective policies and interventions should be complemented by other recommended measures. Identifying and implementing a combination of evidence-based strategies that are appropriate for local conditions at the country level will likely require strong technical assistance. This is particularly true for health departments or agencies who have responsibilities for areas which are not limited to health service interventions, such as taxation, legislative measures or consideration of health protection from alcohol- related harm in trade negotiations.

Building capacity, both within alcohol and in concert with other sectors and programs, was another leading priority. New partnerships and appropriate engagement of all relevant stakeholders are needed to support the implementation of practical and focused technical packages that can ensure returns on investments by reducing the harmful use of alcohol at the population level. A new WHO-led initiative, SAFER, focused on the implementation of cost-effective priority interventions ('best buys") and other recommended alcohol-control measures at country level, has been developed to invigorate action in countries through coordinated actions of WHO partners within and beyond the United Nations system.

At regional level, the participants also recommended the dissemination of essential information for public servants working on alcohol related topics; supporting country implementation of SAFER; support for activities related to preventing and understanding fetal alcohol spectrum disorders; the development of guidance on alcohol dependence and referral systems; documentation of best practices from within the region, as well as on the return of investing in the best buys; and a social media took kit for campaigns, to support technical cooperation activities related to alcohol policies and interventions. The importance of collaborative research on alcohol related topics was also emphasized.

5.3 Production and dissemination of knowledge

Since the previous edition of the WHO *Global status report on alcohol and health* (followed by regional reports on alcohol and health), the data available on alcohol consumption – including its impact on health and development, and the effectiveness and cost-effectiveness of policy responses – have improved significantly. Because of recent developments in national monitoring and surveillance systems, countries are in a better position to collect, collate and disseminate reliable information on alcohol use, its health and social consequences and policy developments. Overcoming gaps in surveilling alcohol use and related harms was often framed as a substantial step that would make it possible for Member States to identify and explain the need for evidence-based strategies that would address their specific challenges. Among Member States with insufficient monitoring systems, there was a recommendation to identify possible synergies with other health risks (e.g., cannabis, mental health) to collect data on consumption and related harms. Despite the progress in monitoring and surveillance, not all Member States in the Americas have cleared this hurdle. Several Member States reported a need for newer technology and additional resources to better track consumption and harms within their borders.

The global monitoring framework for control of NCDs and the SDGs of the 2030 Agenda for Sustainable Development provide new impetus to the development of national monitoring systems and present new challenges for data collection and analysis at the global level, regional and national levels. Effective monitoring of total per capital alcohol consumption (APC) and of treatment coverage for substance use disorders require not only streamlined and simplified data generation, collection, validation and reporting procedures for indicators on alcohol consumption -- allowing regular updates of country-level data at 1–2-year intervals with minimized time lags from data collection to reporting -- but also significant methodological advances in treatment coverage indicators. PAHO has developed a tool for the calculation of APC that can be used at the country level.

5.4 Resource mobilization

The statement that the "magnitude of alcohol-attributable disease and social burden is in sharp contradiction with the resources available at all levels to reduce the harmful use of alcohol" continues to be true nine years after the endorsement of the Global strategy, when this statement first appeared. There are no big donors with a strong interest in supporting work to reduce the harmful use of alcohol worldwide or in high-burden countries. The successes in some jurisdictions were achieved, with internal resources using the most cost-effective interventions promoted by WHO. Positive changes in alcohol policies -- and subsequently in levels and patterns of alcohol consumption and associated mortality and morbidity -- in countries where drinking is heavily embedded in cultural norms and traditions indicate that progressive alcohol policy developments are feasible in spite of all challenges. Indeed, they can bring public health benefits and returns on investments within relatively short periods of time. Alcohol consumption is the leading risk factor worldwide, and in the Americas, for people aged 15–49 years – the segment of the population which plays a significant role in the economic and social development of every nation. Increasing awareness of the impact of harmful use of alcohol on child development and maternal health as well as on infectious diseases such as tuberculosis and HIV, road traffic injuries and interpersonal violence may change the situation about funding support for alcohol policy and program developments, but this is yet to happen.

The lack of resources to finance prevention and treatment program and interventions for substance use disorders calls for innovative funding mechanisms to address related SDG targets. Several innovative approaches that combine evidence-based knowledge with more “out of the box” ideas have been reported across countries and at the international level. Recently the WHO Independent High-Level Commission on NCDs recommended exploring the possibility of establishing a Global Solidarity Tobacco and Alcohol Contribution as a voluntary innovative financing mechanism to be used for the prevention and treatment of NCDs. There are existing examples of revenues from taxes on alcoholic beverages being used to fund health promotion initiatives, health coverage of vulnerable populations and/or prevention and treatment of alcohol and substance use disorders, as well as, in some cases, supporting international work in these areas. Other ideas for innovative funding mechanisms are directly linked to the notion that governments have the overall responsibility to implement preventive strategies and interventions and to provide access to treatment for affected persons for conditions that directly stem from the consumption of substances or services which are legally traded or operated, such as alcohol or gambling services. There are examples where earmarked funding for the prevention and treatment of substance use disorders and related conditions is provided with funds generated from state-owned retail monopolies, from a profit levy across alcohol beverage value chains, from taxing alcohol advertising, from imposing earmarked fines for noncompliance with alcohol regulations, or from taxation and excise duties on casinos and other forms of gambling. Finally, Member States suggested that developing an online repository or communities of practice would allow countries to not duplicate efforts by sharing policies, policy templates, best practices, and skills across the region.

6 CONCLUSIONS

The harmful use of alcohol causes over 3 million deaths per year, is responsible for 5.1% of the global burden of disease expressed in DALYs and continues to be one of the leading risk factors for poor health globally. According to the most recent estimates in a global comparative risk assessment, alcohol was the seventh leading risk factor for death and disability in 2016 and the top risk factor among the world's population aged 15–49 years.

The Global strategy to reduce the harmful use of alcohol, negotiated and agreed by WHO Member States in 2010 (Resolution WHA63.13), represents international consensus that reducing the harmful use of alcohol and its associated health and social burden is a public health priority. At the regional level, it led to the adoption of a regional plan of action to implement the Global strategy in 2011.

Despite significant efforts by the WHO and PAHO, there has not been progress in reducing the total per capita alcohol consumption worldwide (except for the European Region) nor in the Region of the Americas. The current trends and projections point towards increase of total per capita consumption worldwide and in the Americas in the next 10 years, that will make the target of 10% relative reduction by 2025 out of reach unless implementation of effective alcohol control measures are implemented in large countries with high consumption levels.

The influence and interference of the alcohol industry is considered a key barrier to making progress on the adoption of the most cost-effective alcohol policies. Other considerable challenges for effective alcohol policy development and implementation remain. These include the culture around alcohol constructed in part via pervasive alcohol marketing and promotion; the lack of effective enforcement of the laws; the lack of a regional or global regulatory framework that would increase country action and the gaps in knowledge and actions around managing conflicts of interest that would prevent the alcohol industry from interfering with the policy making process.

The three effective and cost-effective "best buys" of alcohol control – limiting physical availability, restricting advertising and marketing, and increasing price through taxation – are the best policy options and tools available to Member States for achieving these reductions in the harmful use of alcohol. There was a clear consensus that strengthening legislation to reduce alcohol-related harms was a leading priority among Member States. To maximize the benefits to the populations in Member States, these effective policies and interventions should be complemented by other recommended measures.

Building capacity, both within alcohol and in concert with other sectors and programs is another leading priority. A new WHO-led initiative, SAFER, focused on the implementation of cost-effective priority interventions ('best buys") and other recommended alcohol-control measures at country level, was considered a priority for technical cooperation activities and for national action by the participants.

At regional level, the dissemination of essential information for public servants working on alcohol related topics; support for activities related to preventing and understanding fetal alcohol spectrum disorders; strengthening alcohol monitoring systems at country level (including how to track alcohol per capita consumption); the development of guidance on alcohol dependence and referral systems; documentation of best practices from within the region, as well as on the return of investing in the best buys; a social media took kit for campaigns, to support activities related to alcohol policies and interventions were recommended as priority areas for technical cooperation.

Moving forward with require strong political leadership and commitment. All participants considered critical the role of WHO and PAHO in providing the tools, guidance and technical support needed to assist countries in effectively reducing harmful use of alcohol. The work of the past 9 years should continue and be expanded, using the WHO Global strategy as the framework for action, while recognizing that an international agreement for alcohol control may be a more effective way to work together globally. Overcoming the interference and influence of the alcohol industry will also require clear guidance and technical support, and it was identified as another priority area of action and collaboration. It is also necessary to increase the allocation of resources at all levels to match the public health relevance of alcohol as a key risk factor for health and development.

7 Appendix I – List of attending countries, their focal points and other attendees

Attending Countries

Antigua and Barbuda
Teri-Ann Joseph
Senior Medical Officer
Clareuve Psychiatric Hospital

Argentina
Debora Duffry
National Director of Mental Health and Addictions

Belize
Esner Vellos
Director
National Drug Abuse Control Council
Ministry of Health

Brazil
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Coordinator of Surveillance and Monitoring of NCDs

Canada
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Director
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Health Canada

Chile
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Department of Mental Health
Ministry of Health

Costa Rica
Gerardo Sánchez Chaverri
Statistician of Process Research
Institute on Alcoholism and Drug Dependence

Cuba
Carmen Borrego
Chief of Mental Health Section
Ministry of Health

Dominica
Martha Jarvis
Director
Drug Abuse Prevention Unit

Dominican Republic
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Technical Coordinator of the Department of Mental Health

Ecuador
Daniela Valdivieso Riofrio
Specialist for the National Director of Health Promotion

El Salvador
Nathalie Larreinaga
Executive Director of FOSALUD

Grenada
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Assistant Drug Control Officer
National Council on Drug Control

Guatemala
Fluvia Aracely Tellez Orellana
Ministry of Public Health and Social Welfare

Guyana
Kavita Singh
Coordinator
Non-Communicable Diseases
Ministry of Public Health

Honduras
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Head of the Addiction Treatment and Rehabilitation Division of IHADFA
Honduran Institute for the Prevention of Alcoholism, Drug Addiction and Drug Dependence

Jamaica
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Director
Non-Communicable Diseases and Injuries Prevention Unit
Health Promotion & Protection Branch
Ministry of Health & Wellness

Mexico
Arturo Sabines
Director of the National Office for Tobacco Control of the National Commission against Addictions

Nicaragua
Joaquín Escoto
National Coordinator of the Program – All with Voice
Ministry of Health

Panama
Aldacira de Bradshaw
National Coordinator of the Mental Health Programme
Ministry of Health

Paraguay
Fulvia Aguilar
Director for Surveillance of Non-Communicable Diseases

Peru
Miguel Angel Hinojosa Mendoza
Psychologist
Professional of the General Directorate of Strategic Interventions in Public Health

Saint Kitts and Nevis
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Ministry of Health, Community Development, Gender Affairs and Social Services

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Substance Abuse Advisory Council Secretariat
Department of Health and Wellness

Saint Vincent and the Grenadines

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Ministry of Health, Wellness and the Environment

Suriname

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Ministry of Health

Trinidad and Tobago

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